Iowa Department of Human Services

Mental Health System Redesign

Children's Disability Workgroup

Discussion Paper # Three: Building Crisis Systems of Care

Prepared by Technical Assistance Collaborative, Inc.
September 27, 2011

I. Introduction

Effective crisis systems of care consist of a multi-system infrastructure of services, interfaces, processes, and pathways that promote early, time-sensitive and least intrusive/restrictive actions and interventions to prevent, mitigate or resolve crisis situations and any accompanying risk. The presence of a full array of crisis services (i.e. crisis intervention, crisis stabilization, acute intervention, CIT[1], Mental Health First Aid) does not in and of itself indicate that crisis care is systematized or coordinated in a manner that achieves objectives. This paper will highlight several attributes of effective crisis systems of care, the development of strategic points of intercept with individuals/families in crisis, and crisis-specific data considerations.

II. Attributes of effective crisis systems of care

Shared and transparent vision for persons in crisis and their families

Effective crisis systems are made up of players and partners who understand the public health goals of the system and who participate in continuous improvement towards those efforts. If the goal is to move care out of emergency departments and into the community then cross-system strategies are developed to promote that outcome. Law Enforcement agencies develop policies that are consistent with that vision. Schools are aware of how to access community-based crisis services. Outpatient providers talk clients about their options in the event of a crisis. Individuals who train community members in mental health first aid accurately describe the service system, pathways to care, and the type of services that are available. Professionals with the authority to initiate an involuntary hold or admission do so after careful consideration of/attempts to engage an individual through a voluntary process.

Planned service pathways that are consistent with level of care need and treatment preference

[1] Crisis Intervention Team (CIT) is a law-enforcement model for intervening with persons with a mental illness. For more information: http://www.citinternational.org/

Hospital emergency departments along with city and county jails have in many communities become de facto providers of crisis services sometimes by default and sometimes by design. However a majority of individuals in crisis can be served in less-restrictive settings in the community that are far more soothing and conducive to crisis resolution. Individuals who receive crisis services in an emergency department are more likely to be hospitalized than those that are seen in the community. A 2002 study found that a "matched sample of consumers who used hospital-based crisis services were 51 percent more likely to be hospitalized, after other variables had been controlled for, than users of community-based mobile crisis services."[2] A number of factors can contribute to this substantially higher admission rate including the following:

- There is often an increased expectancy of hospitalization by the person in crisis, the family, the referring provider when care is accessed in an emergency department. A suitcase may already be packed and preparations made for time away from home.
- When crisis intervention is delivered in an emergency department if a person is not hospitalized they are discharged to a "lesser" level of care and this may be perceived by the emergency department physician as too big of a risk. This is not the case if the service is delivered in a community setting such as a home.
- Hospital emergency departments often have insufficient relationships with behavioral health services providers, are unable to secure timely follow-up treatment and may not have confidence that the treatment will be sufficient to address the risk.
- The emergency department setting may contribute to an escalation of the crisis. Despite the best efforts of staff, ED's can be perceived as loud, crowded, chaotic, non-private, stimulating, threatening and frightening.
- The pace of the work and the need to move people through the ED service as quickly as possible makes it difficult to engage in effective crisis resolution. This can be a particular concern when there was no treatment need (i.e. co-existing medical condition) for being seen at an ED level of care

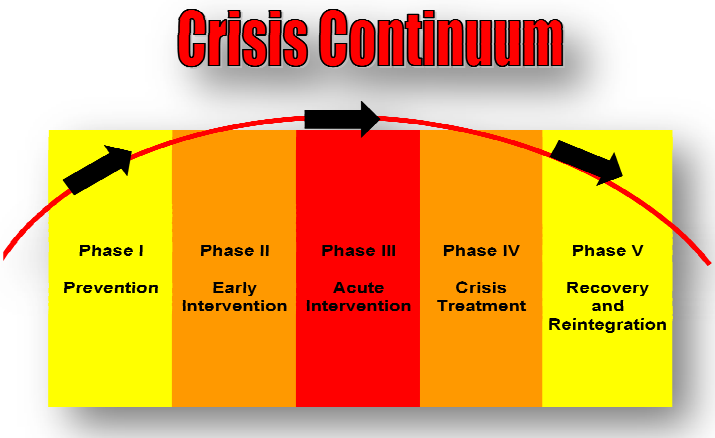
The adoption of an exception-based practice model is helpful i.e. "Crisis Intervention Services are delivered in the community rather than in the emergency department except when…" For children and adolescents it is reasonable to expect that 80-90% of children can receive crisis intervention services outside of an emergency department.

<u>Services are mobile and available in home, school or other community setting</u>

[2] Shenyang Guo, David E. Biegel, Jeffrey A. Johnsen, and Hayne Dyches
Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization
Psychiatr Serv, Feb 2001; 52: 223 - 228.

When given a choice, many families will opt to receive crisis services in the home or school setting. Families may find it more convenient and discreet, less disruptive and more comfortable for the child. When delivered in a home, school, or congregate care setting the mobile crisis clinician can get a clearer idea of the child's environment and elements that are either escalating or calming. Clinicians can offer support and consultation to parents, school personnel or facility staff. Collaborative plans can be developed to prevent a placement or school disruption.

<u>Upstream interventions are identified and promoted across levels of care</u>



Effective crisis systems of care invest in practices that span the crisis continuum and expect that all service providers see themselves as playing an active role in management at all points of the crisis continuum. Crisis teams are positioned to respond when a crisis is becoming acute, but are not positioned to focus on crisis prevention or to be alert to early signs of a crisis. Assisting a child and family with the development an effective safety plan necessitates that a treatment provider is competent in crisis management. In order to respond effectively to early indicators of a crisis a treatment program should have built-in response mechanisms such as meaningful 24/7on-call service, the ability to accommodate short-notice appointments, availability of in-house consultation and skills in crisis resolution. After a crisis episode or course of hospitalization, the same program must be equipped to assess for residual risk, re-evaluate the treatment plan and safety plan and perhaps to increase the frequency of services for a period of time. None of this is meant to imply that outpatient treatment providers should never refer for crisis services. It is more about shifting the bar—maximizing the in-house capacity and having permission to meet more of the needs of their clients without having to involve a higher level of care. It is an upstream intervention by a provider who already knows the client. Crisis responsibilities might be woven into service definitions or performance specifications. The use of MOU's or affiliation agreements between treatment providers and crisis teams might facilitate care coordination

<u>"Crisis Intervention" is designed as a treatment service</u>

Crisis teams are underutilized when the predominant purpose of the service is to do a level of care determination or screening for hospitalization. The opportunity in a crisis is to deliver a course of care with a goal of crisis resolution, mitigation of risk and perhaps the provision of

some coaching or education, facilitating some planning, or assisting in system navigation or care coordination. If the course of treatment fails to bring sufficient relief or resolution, then additional actions—that may be in the form of inpatient hospitalization, crisis respite, urgent psychiatric appointment or use of natural or informal supports—are discussed with pros and cons considered. It is important to remember that hospitalization is a not a resolution—it's a disposition that may or may not lead to relief or resolution and the potential benefit of it or any considered plan should be weighed against the potential risk so that an informed and shared decision can be made.

Interventions are change-oriented, person/family-centered and strength's-based

In nearly every crisis situation there are multiple ways to reduce risk or solve a problem. Consistent with systems of care principles, when we really listen to kids and families about their priorities, and work with them to identify logical solutions, it is easier to gain consensus on a plan and motivation is higher and outcomes are better. Lasting change cannot be externally imposed—it comes from within. Attention to a child or parent's stage of change[3] readiness reduces allows us to join with the person where they are in their journey and promotes use of stage-consistent engagement and intervention strategies.

Specific attention is paid to the experience of the parent or caregiver

The nature of the crisis—from the shoes and perspective of a parent or guardian—can be significantly different from the nature of the crisis from the child's perspective. Effective crisis resolution requires specific attention to each of these perspectives. A child might define the crisis as "The teachers at school keep picking on me—that's why I get angry." The child's parent might define it differently, "If I have to leave work to pick my child up from school again, I will be fired." Several states (including Iowa) are successfully using parent support partners or family partners who have lived experience as parents/caregivers of children with disabilities to provide peer to peer supports.

III. Strategic points of intercept for children and families

Within a crisis system of care model attention is paid to identifying practice patterns that are leading to an overuse of intensive, restrictive or involuntary services and designing upstream intercepts to change the practice pattern. Some potential points of intercept have been identified by the workgroup and are included in the following examples:

- High volume of referrals from inpatient psychiatric unit to residential treatment facilities

[3] The Stages of Change Model was originally developed in the late 1970's and early 1980's by James Prochaska and Carlo DiClemente

    - Potential intercept: Community team provides a hospital-based consult working with child, parents and facility to consider alternate plan
- Transfers from congregate treatment facility to emergency departments due to acting out behavior or crisis situations
    - Potential intercept: Rather than sending children to emergency departments, facilities request mobile crisis intervention service
    - Potential intercept: Treatment facility expands in-house capacity to manage first response to crisis situation, coaching and consultation with direct care staff, and developing individualized plan. This shifts the bar on when an outside crisis team is called.
- High number of involuntary holds are being initiated by a particular agency, hospital or law enforcement department
    - Potential intercept: Collaborating with this system partner, educating on crisis system of care goals, discussing practice pattern, devising mutually-agreeable alternative

IV. Crisis-specific data considerations

There may be a number of ways to enhance the crisis system of care "data set" especially if it is gathered within multiple systems and then pulled together in a more integrated dashboard fashion allowing multiple data points to be considered at the same time. Examples:

<u>Outlier data</u>

- # of involuntary holds initiated
- # of involuntary admissions
- # of referrals to ED instead of community-based crisis service (by referral source)

<u>Non-community discharges</u>

- # of moves between like LOC's (from one residential center to another OR from one hospital to another)
- From a residential center to a hospital
- From a hospital to a residential center

<u>Practice pattern data</u>

- Time of day/day of week that ED is being used
- # of times family calls treatment provider first and then a crisis provider

- Average length of time between end of a crisis episode and next FTF appointment with treatment provider

System Partner Data

- Crisis-related call for law enforcement
- Volume of 911 calls to schools due to BH crises

V. Final note for workgroup members

Included in the reading materials for the September 27th Children's Workgroup session are a number of papers related to effective crisis service delivery. This includes SAMHSA's *Practice Guideline: Core Elements in Responding to Mental Health Crises*, Joan Beasley and Kathryn duPree's Monograph, *A Systematic Evaluation and Implementation Strategy to Promote Effective Community Service Systems for Individuals with Coexisting Developmental Disabilities* and Friesen, Katz-Leavy and Nicholson's, *Supporting Parents With Mental Health Needs in Systems of Care.*